Concurrent Session One – Intervention Quality/Scientific Basis

Qairo Ali
Facilitator
CDC/PPB

The facilitator, Qairo Ali, welcomed participants to the session and shared her expectations for a fun and interactive meeting. She then briefly reviewed the three main session objectives, which were to:

- ❏ Become more familiar with CDC's requirements for documenting the evidence or theory basis for interventions and their justification for application to the target population and setting (intervention quality/scientific basis);
- ❏ Learn how health department colleagues are securing information from their grantees on intervention quality/scientific basis; and
- ❏ Learn various methods to assure high quality, "scientifically" based interventions.

Qairo Ali then explained that the objectives would be accomplished through the use of several activities, including:

- ❏ An overview of where the CDC currently is with regard to intervention;
- ❏ A presentation by a health department representative describing a personal experience with intervention;
- ❏ A presentation by two CDC representatives, members of the Science Application Team, explaining one approach for improving the quality of intervention;
- ❏ A group activity, which would allow participants to meet each other and share information.

Marlene Glassman
CDC Representative
CDC/PERB

Marlene Glassman, CDC representative, spoke about what the CDC wanted to gain from the meeting. She briefly reviewed the Intervention Plan Form, specifically noting the main changes to the ethnicity and race categories. She said that the form related to intervention planning for

the upcoming year. She explained that her focus would be on the second page of the Intervention Plan Form, specifically, boxes seven and eight. She said that "intervention quality/scientific basis" referred to "the evidence or theory basis for the intervention and justification for application to the target population and setting." She noted that the form asked for an indication of evidence or theory basis and if the intervention is justified for the target population and setting. She said that box eight referred to the service delivery plan.

Marlene Glassman then summarized what the CDC wanted for the issue of scientific basis and quality of interventions:

- ❑ A determination about the sufficiency of the evidence used in the development of each intervention: evidence or theory basis for the intervention;

- ❑ A determination about the intervention's justification for application to the target population and setting;

- ❑ A determination about the sufficiency of the service delivery plan. She explained that the service delivery plan should address such issues as:

    - ➜ Format, setting, content and delivery of the intervention
    - ➜ A realistic plan for reaching the proposed number and type of clients
    - ➜ Provider training and supervision
    - ➜ Quality assurance and accountability mechanisms

Marlene Glassman acknowledged that the CDC does want a lot of information, although she said that they do try to provide helpful resources. She mentioned that some of these resources include Volume 1 of the Health Department Evaluation Guidance, Volume 2 of the Supplemental Handbook and forthcoming information on documenting evidence, which would be provided later in the session.

Marlene Glassman said that health department staffs have been working on this for the past year and already have some knowledge of the process. She said that she has seen creative and effective ways of providing the necessary information.

Molly Herrmann
Community Planning Coordinator
AIDS/HIV Program - Wisconsin Division of Public Health

Molly Herrmann said that while she is the Community Planning Coordinator, she has also been pulled into evaluation. She said that her presentation would cover how Evaluation Guidance has affected Wisconsin, and also what they have done with quality and scientific basis. She

explained that she would begin by speaking about their system prior to Evaluation Guidance.

Steps Toward Improving Interventions Prior to the Evaluation Guidance

- ❑ Systems of support, including:
  - ➜ An Evaluation Work Group;
  - ➜ 10% evaluation requirement on work plans from grantees;
  - ➜ One full-time evaluator plus portions of other staff;
  - ➜ Contracts with some Wisconsin community based organizations to provide technical assistance and evaluation background to other CBO's (generally minority CBO's);
  - ➜ Evaluation of Prevention for HIV-Infected Persons Project (PHIPP) by Center for AIDS Intervention Research (CAIR).

- ❑ New forms for grantees to explain the distinction between "contacts" and "interactions." She said that a "contact" is a typical outreach encounter, usually very brief, while an "interaction" generally takes place in a one-on-one or group setting where the participant demonstrates some sort of behavior (rather than simply listening or observing).

- ❑ "Less is more" message to move away from number orientation and toward interactions. Contacts are used as a bridge to pull people into more intensive interventions.

- ❑ Philosophy that grantees will enter and use their own data.

Chronology for Implementing Evaluation Guidance

- ❑ 3/00 - Attend Evaluation Guidance training in Atlanta.
- ❑ 3-4/00 - Develop plan for implementation of Evaluation Guidance in Wisconsin.
- ❑ 4-5/00 - Discuss Evaluation Guidance with the Community Planning Group (CPG).
- ❑ 5-8/00 - Rewrite CPG plan to incorporate populations.
- ❑ 6/00 - Discuss Intervention Plan with Evaluation Work Group.
- ❑ 9-11/00 - Two-day mandatory training for grantees (introduction to population intervention taxonomy and intervention plans) and seven technical assistance meetings with agencies to receive information and incorporate it into intervention plans.
- ❑ 12/00 - Grantees submit intervention plans (many went past the due date).

Ms. Herrmann said that they have received positive feedback from grantees on the new system. Previous work plans were very broad, and now they provide more structure and examples. She said that future plans include an RFP to be released this summer, as well as new contracts, based on the RFP, beginning in February of 2002.

Intervention Plans Training and Technical Assistance

Ms. Herrmann said that they provided technical assistance for the intervention plans because they were asking their grantees to buy into a completely new form that appeared to be a lot of work. The two-day training helped the grantees, as well as the on-site meetings. She said that a lot of people were not at the two-day training and, therefore, some of the discussion at the on-site meetings dealt with clarification of the populations and interventions, and figuring out solutions for combining efforts and consolidating plans.

She said they were able to give some guidelines for consolidation, such as having one FTE work on two plans. Each intervention plan then received two to three rounds of feedback, which was a long and tedious process. Some of the feedback given to these plans was that they were actually not fundable as written. Since they were already in the funding cycle, they were not going to de-fund anyone; however, they were able to send a strong message about making changes to these interventions.

Population/Intervention Summary Table

Molly Herrmann said that participants' packets included a one-page summary of the population/intervention table. She said that this was the meat of what they first introduced to their grantees to get them to buy into the system. The table includes interventions as of April 2001; however, she did note that some interventions have dropped and others have been picked up. She said there are approximately 90 intervention plans from across the state with approximately one-third Group level, one-sixth Health Communication/Public Information, one-sixth Counseling/Testing and the remainder broken down by population of:

- ❑ 34% MSM & MSM/IDU
- ❑ 30% Heterosexual risk
- ❑ 7% IDU
- ❑ 7% General population
- ❑ 22% Various populations (CTS, capacity-building)

She explained that Wisconsin was a state where heterosexual risk was over-funded. They tried to shift people more toward the MSM and MSM/IDU categories, as well as addiction drug use on its own. As far as heterosexual risk, they used CTS definitions as a basis for defining low, moderate and high risk. They told their grantees that if they serve people with opposite sex sexual partners, who are not injection drug users, then they should focus on the partners-of group. These include partners of MSM, partners of injection drug users and partners of those with HIV. They also included some of the moderate risk CTS definitions, such as a person who has been forced to have sex, sex while drunk/high, having an STD or being a sex trader.

Molly Herrmann noted that there was a lot of discussion about multiple partners and that many could not buy into it because the boundaries were so vague – did it mean more than one partner during a lifetime or lots of partners in a year? She and her colleagues decided not to reinforce a subjective belief and kept it out. She also said that they changed "mother at-risk for HIV" to simply "a pregnant woman with HIV."

Intervention Plan Forms

Molly Herrmann said that the form she was describing is the most often used two pages in the plan from the Community Planning Group. She said that they frequently refer people to it when they have questions about how their clients fit in. They separated the interventions into the following categories:

- ❑ Individual
- ❑ Group
- ❑ Prevention Case Management
- ❑ Outreach
- ❑ Counseling/Testing
- ❑ Capacity-building (to agencies or populations)
- ❑ Health Communication/Public Information (separation of WHIRC)

She explained that the Wisconsin Hotline Information Resource Center (WHIRC) is very different from a lot of the other HC/PI that is done, given that a lot of the other HC/PI entails handing someone a brochure or doing a brief one-on-one. That is why they decided to keep the WHIRC on its own. A couple of exceptions included Partner Counseling Referral Services (because these are not performed by grantees in Wisconsin), and community level interventions. They decided that a lot of the things that were being defined as community level interventions were really something else – usually either outreach or HC/PI. She explained that they did not want to have a vague list for the grantees, and so they decided not to include it.

Molly Herrmann then pointed out the Logic Model sheet that organizes what things need to be included in an intervention plan for it to work and also what the state needs in order to know that it will work. She noted that the last row contained corresponding parts of one of their intervention plans.

She then went onto the example of a Group Level Intervention Plan Form and indicated that most questions asked of them and most revisions that grantees got back had to do with Section (6). She said that the form has been revised and is currently up-to-date, and she walked through the beginning section of agency information. She said they added the organizational profile to have the agency talk about their capacity to serve in general, not necessarily their capacity to do a particular intervention, but to do other things (fiscal management) to ascertain whether they are

a solid and grounded agency.

She moved to Section (6) relating to need and justification. She explained that they included a separate form with examples and instructions in order to minimize the appearance of a confusing, instruction-clogged form. Discussion of Section (6) was broken down into the various sub-sections.

Section (6A) "Identified need for reaching the specified population" – She said this essentially means – "Why does this group of people need some sort of HIV services?" She said grantees could use resources, such as epidemiology data and focus group feedback to determine the need for outreach.

Section (6B) "Evidence basis for the intervention" which means – "Why is this intervention effective in general?" They referred a lot of grantees to their community plan because it had been written with all of the evaluation guidance taxonomy in it and they could easily direct them to specific citations. She said that what used to happen is that they would say, "group level works" and grantees would submit a plan saying, "group level works." Even though they might be telling grantees where to look for citations, she said a lot of citations came in that were not from the plan and, therefore, the previous circular process was improved. Some had been using scientific basis the whole time and they hadn't been asking in such a way that grantees would indicate that.

Section (6C) "Justification for using this intervention for the specified population" is essentially a combination of the previous two sections. She used an example of knowing that MSM needs some sort of intervention and that outreach has been proven to work. Now, she said, this section means "Why should you put those two together?" Why these people? Why this intervention? Why did you put them together? She said an example might be using feedback from outreach they've been doing with women who indicated that they'd really like a sit-down, group-level meeting once per week where they could feel safe and bring in refreshments.

Molly Herrmann said that Sections 6 (A), (B) and (C) were definitely the most confusing for the grantees. She said they re-wrote the instructions to simplify what they were asking for. She said a lot of times grantees would have the correct information in the wrong sections.

Section (6D) "Anticipated measurable outcomes" has changed a lot since last year in that they've added more guidance. In previous years, it only read "anticipated measurable outcomes" with an open box. They they decided to name some things that might happen in a group session. There would be some people that were contacted to be in one; a smaller group would come to at least one; some would come to at least three and so on. She said they are asking them to predict what might happen as a result. She noted that the number tension was reduced because it is okay that the number gets smaller down the line. She said that ten participants out of 100 is considered

reasonable and they provide a place to at least indicate that 100 people were contacted in order to give the grantees some credit.

Molly Herrmann then explained that Section (7) was intended to be very brief, especially the "content/messages" section of (7A). She said that listing a few key phrases of what they might talk about is sufficient for this section. She noted that Section (7C) could be tied back to Section (6B) in explaining how they will find out what the outcomes are. Section (7E) was intended to move away from long, drawn-out work plans that simply indicate "on-going" for everything. She said the instructions actually tell grantees to only list plans that have dates. She said the "on-going" plans don't help with capturing concrete results.

Molly Herrmann said she looked at about one-third of the intervention plans and gave feedback on them. The overall feedback they've heard has been positive, even though it looked like a lot of work, and it was tedious to go through the training. However, it allowed them to go out to their grantees offices one more time to do TA in the fall. She said that the more help they gave the grantees, the more accepting they were of the forms, and that it really looks like they do more, and they can really show what they're doing.

In conclusion, Molly Herrmann said that the result of Evaluation Guidance in Wisconsin is that they waive this foundation for the potential RFP. She said that implementing the Evaluation Guidance has required a significant amount of resources and time because it takes a long time to review 90 intervention plans, especially since some went through as many as four revisions. She said the grantees have varying capacity to use the intervention plans and data collection forms. It's not always that they are not up-to-speed, but it could be computer-related or other concrete forms of lack of capacity. The grantees seem to prefer the intervention plans because there are concrete boxes to put things in, and it looks like everything grantees are doing is actually recorded.

Discussion Summary:

- There was a question regarding whether the form would be a substitute for a proposal or if it would actually be used in addition to a proposal. Molly Herrmann responded that if the RFP goes through, this would be a self-standing document. She said she would submit this if she wanted to do, for example, group level for women – there are sections about agency background, population and how the intervention would be conducted. They beefed it up a lot so that it could be used as a self-standing proposal. She did point out that there are certain sections they could repeat, such as the agency section. If an agency was submitting several of these, they might have to cut and paste particular information.

- A question arose about whether or not this would be an annual plan. Molly Herrmann

said that it would be an annual plan, just like the work plans were before.

- There was an inquiry related to the average number of intervention plans per agency. Molly Herrmann gave an example from the Northern Region AIDS Service Organization, which indicated that they have two staff and five intervention plans. Another public health region has three or four staff and seven, eight or nine intervention plans. She said they try to get no more than two to three intervention plans per person and that it really depends on the size of the agency. A large agency, The AIDS Resource Center in Milwaukee, has 19. She did point out that these included sub-contracts, and that agencies that were sub-contracted through one of their direct contracts also filled out the forms.

- A question was posed about those grantees that did not have strong theory based or evidence based interventions. The participant wanted to know what types of agencies they were, what populations they were working with and what type of support they received. Molly Herrmann said that, for the most part, the AIDS service organizations "got it." She did say there were a few CBO's that needed a little more assistance and that these tended to be those organizations that were serving what they defined as "heterosexual risk." However, they were serving questionable populations, such as school children and young, pregnant women. She said that if someone said they worked at a community center, there needed to be justification that it wasn't simply because there were a lot of kids in the neighborhood, but that there was a high STD rate or evidence of a lot of risk behaviors or other factors. She said that it was a mix between the AIDS service organizations and some community based organizations. The only intervention plan that she passed with no corrections was from a sub-contract agency that works with people with developmental disabilities and it was only for $8,000. She said they got it and had all of the evidence. They did make themselves very available for technical assistance and explained that there are also two CBO's in Wisconsin, one of which is the Black Health Coalition, that are actually paid to provide technical assistance to their CBO peers.

- A question was asked about how identifying need from Section (6A) relates back to the RFP itself. Molly Herrmann said that the Community Planning Group did a priority setting process over the winter that resulted in percentages of how the council thought that resources should be allocated to different populations. She said they over-shot epidemiology data in a positive direction. She gave an example that the general population in Wisconsin is 90% white and 10% minority; however, the epidemiology data shows that over 50% of the new infections are among people of color. The council recommended that 76% of resources should go towards people of color and 24% towards non-minority individuals. The council made a strong statement that challenged them toward the trends, rather than the data. They didn't do any interventions, but instead only did priority setting for populations and sub-populations because their populations are

behaviorally defined and some sub-populations talked about minorities and different age groups. If the RFP goes through, the council's recommendations would be used as a guideline for how they would like the money to be spent in Wisconsin. The council set priorities that will inform the next funding cycle directly.

- ❖ One participant inquired about whether the agencies must report and justify accomplishments from previous funding. There was a concern about grant review committees not receiving that data and, in turn, approving plans that do not impact a wide population. Molly Herrmann said that they do receive quarterly reports from agencies to see if they are on target for the year. She noted that new intervention plans and work plans have been submitted annually, but it was a four-year funding cycle. They'd need a very good reason to de-fund an agency because they are already in a four-year contract situation. Having agencies submit a new plan each year gives them the opportunity to re-write those that would not be considered for funding.

- ❖ A question was asked about whether or not categories of evidence were actually developed for Section (6B). Molly Herrmann said that there were five or six people who reviewed the intervention plans and a process of acceptability. It eventually came down to herself and one other person doing the final check on the plans, and they worked very closely. She explained that they were not prepared for how much technical assistance they were going to have to give and they didn't have much time between the September training and when they actually went out. They tried to overlap during the technical assistance portion to include one new person and one familiar with the process to maintain consistency.

Charles Collins
CDC Representative
CDC/CBB

Charles Collins indicated that he and Dale Stratford would be facilitating an informal dialogue, in which they wanted the participants to be active, about eliciting the scientific basis or evidence basis for particular programs. He distributed a handout that illustrated four patterns that frequently happen with evidence based programs:

- ❑ *Formal Theory:* Charles Collins explained that this is the path of taking formal behavioral theory – transtheoretical, health belief model, stages of change – and using that theory to take the pieces apart and design program elements around those pieces of the theory to create a prevention program.

- ❑ *Evidence-Based Model:* Charles Collins said that the CDC has invested greatly in this path and through the process of the Synthesis Project, they were able to identify

programs that worked. They published a document called The Compendium of Effective Programs and explained that people are taking these programs and replicating them.

- ❑ *Replication of a Program with Adaptation:* Charles Collins said that when effective programs (such as The Popular Opinion Leader, Voices and Empowerment) come to the state level, the funding that CBO's get to implement these interventions is not nearly as great as the funding that the original researchers got to do the research. He said it is simply a reality of the situation and that frequently the CBO's have to adapt or tailor the original research to fit their population and resources. He said these two paths have to do with replication and then replication with tailoring.

- ❑ *Implicit or Informal Theory:* Charles Collins said that they have found that, frequently, CBO interventions are not started with formal theory or with The Compendium of Effective Programs, but are started with the common sense assumptions of the community – with the community thinking about the problem and thinking about how they will go about doing this.

Charles Collins said that of these four paths, formal theory seems to apply more to new programs and informal theory seems more common with established CBO's – with people in the community implementing their ideas about HIV prevention. He then posed the question, "How do we dialogue with community about their informal theory?"

Discussion Summary:

- ❖ A participant from New York City suggested working with the CBO's to back into the formal theory by looking at, from a common sense perspective, what they have identified as the needs of their population. This was said to be useful for seeing connections and creating more explicit and articulated interventions. She said they are currently doing this in New York City.

- ❖ Charles Collins said that Laura Leviton made the same point in an earlier presentation – that of going in and identifying what the informal theory is to indicate ways of backing into evidence based programs or theory based programs. He asked for more suggestions of ways to open a dialogue that would help honor the CBO's informal theory and yet still start to integrate components of formal behavior change theory.

- ❖ Another point was raised that they want to be able to understand why something works in the informal/implicit theory and also with the adaptation issue. Why does this work? Why is it appropriate?

- A participant from New York City responded to the inquiry saying that one of the places that they start with the informal dialogue is to say, "What benefit is it going to give to the CBO?" She said that often CBO's have to write proposals for grants, and that a lot of the grantors ask for a theory based intervention. They want to help build the capacity of the CBO's to be successful. In New York City, they are approaching it in a couple of ways: being successful in terms of the grant applications and also being successful by demonstrating a difference in the lives of the clients by using a theory and testing a hypothesis that comes from the theory. When they issue RFP's, they find a number of different theories that are HIV related and ask the CBO's to identify in their proposals which theory comes closest to the approach that they're taking in their organizations. Also, they're trying to build in training and technical assistance for the organizations by having presentations in behavioral theory that relates to HIV prevention programs. This includes helping individuals that work with the organization identify one aspect of an intervention for evaluation to talk about what theory that relates to. They are not doing it comprehensively across the board at the moment because it is expensive, but they are doing it incrementally and they do have a vision of where they will be in five years. So, they present certain behavior change theories in the RFA, asking CBO's to identify the closest theory to what they are doing in practice. However, the CBO's can also present some other evidence based approach as an alternative.

- A Georgia participant said that they do the exact same thing in Georgia; however, she said they ask the CBO's to take the theory from the community, write the proposal and then they fund the organization to do a needs assessment based on that. From that needs assessment, they would back into a more scientific based intervention for the particular population they would serve.

- An inquiry was made relating to how many health departments ask their contractors/CBO's to make explicit their thoughts and experience through the use of a logic model, and whether this exercise was beneficial for understanding the interventions that the CBO's are proposing.

- A participant from Connecticut said that for the past four years they have had The HIV Evaluation Bank. She said they work with their contractors to talk to them about science based interventions and this includes a lot of site based technical assistance and training. She said they started out by using a logic model as a way to back into how to create science driven interventions. She said the department has adopted it as a way to devise a work plan and to help people think about how to design their interventions in science. She said it's been very effective in Connecticut.

- Another participant from Connecticut added that she now works for the health department and is in the process of trying to develop an RFP integrating the evaluation

guidance and integrating what they've requested from contractors in the past (logic model, separate work plan). She's trying to integrate the steps of the logic model, the steps of the work plan and the requirements of the evaluation guidance into a form that will be user-friendly and not too difficult for CBO's. She explained that the CBO's in Connecticut will have great difficulty putting their proposals together and that if they use things that are evidence based or use citations, she said they would probably be doing it because they think that's what the health department wants – not because they necessarily have confidence that they'll be able to do that intervention. They're trying to provide some capacity building around that because it's difficult. She noted that if she were a program director for a CBO told to replicate a model out of the Compendium, she didn't think she could do it. Realistic experiences have to be taken into account and that is part of the challenge.

- A participant from Texas said that they are planning to move in this direction, although they are not doing it now. They are planning to put logic modeling into their RFP for the next funding cycle. They are trying to avoid the words "logic model" and "behavioral theory" but still incorporate those into the RFP. He explained that they want to get people to lay out the risk behaviors and even describe health-promoting behaviors they are trying to produce in their clients. This would be connected to behavioral determinates, which is where the theory comes in, and then go to the next stage of determining what behavior change they are trying to achieve. It's very behavior oriented and he is not sure that their behavioral risk factor data is good enough to support all that they're trying to do. They've come at this from trying to do outcome monitoring for the last few years and they've found that they can't do it because their programs are either not designed well enough, or they don't know their design well enough, to develop evaluation questions that are specific enough to get any results.

- Charles Collins explained that the disconnect for those working at CDC is that in many cases they have to stand by the evidence of something working. They have to err on the side of conservative science. There is a culture at the CDC to favor the first two columns (formal theory/evidence based); however, CBO's across the country do not favor these. He said the dialogue they are reaching for is to learn more about what the CDC struggles with and also to learn what the states struggle with, in terms of making programs more evidence based/science based, but in a way that honors grass-roots creativity and the history of working within the community.

- A participant then made an inquiry in reference to the majority who indicated that there had to be some adaptation in order to replicate an intervention. He wondered the extent to which that adaptation has been chronicled, and also who is asking the question around capturing the informal theory, and then backing in. Since CBO's are community driven, and that there is buy-in from the community to evidence based practices, then there needs

to be a continual dialogue in the form of a partnership.

- A point was made that informal theory, also known as grounded theory because it's on the ground building up, often has elements of formal theory. It's important to make that connection with the CBO's. Most of those in academia often try to bridge theory and application, so it's important to connect with CBO's and have them understand that it's important for them to also teach about application and applying it to theory.

- A participant from Connecticut discussed a pilot program in the state of Connecticut. She said that they have been interested in the issue of bridging science to the practice, and they've discovered a disjuncture in the language and communication between scientists and CBO's. They did a pilot run of The Community Evaluation Fellowship, where they asked for volunteer contractors to spend several months with them in an informal setting, which was actually her house. She said they sit around, eat bagels, drink coffee and talk. The only requirement is that they come in with a glimmer of an idea of what they want to evaluate. The scientists in the room are behavioral social scientists from the University of Connecticut and Yale. Their six CBO's have moved from designing science based evaluation plans and they are spending the summer with students from UCONN to help design their instruments and collect their data. They will meet again in the fall to talk about what to do with the data that has been collected and discuss ideas for analyzing and interpreting data for the various constituencies that CBO's serve. She thought it had been a wonderful experience.

- Gary Uhl, with PERB, commented that the environment will probably change in the next few years because of the upcoming requirements for CBO's regarding process monitoring and outcome monitoring. He said the guidances for those will be coming out shortly, along with additional technology transfer tools and training. He said CBO's will probably end up being much better versed in terminology and strategies.

Charles Collins
Group Activity

Charles Collins then gave instructions for a group activity, indicating that each participant was given a different colored card to correspond with colors assigned to the four paths (Pink = formal theory; Yellow = replicating science based programs; Green = tailoring evidence based programs to fit local situations; Blue = informal theory). He asked that participants with the same colored cards get together and identify the three major benefits and three major barriers that a health department would have in specifying grantees use the particular theory. The following presentations were made by each group:

Informal Theory (blue):

Pros

- ❑ It's non-threatening and consistent
- ❑ It's experience-related – coming out of a community that is using it
- ❑ It's easily "generalizeable" - replicable and applicable to the communities (people recognize themselves in it)
- ❑ It's best for encouraging improvement and empowering the CBO (easier to back into formal theory if they can see that what they're doing actually does have a rational basis)

Cons

- ❑ It hasn't been evaluated.
- ❑ It can be perceived as non-scientific and de-valued by scientific community/funders.
- ❑ It will take a lot of money to test it.

Charles Collins reiterated that one con could be that the scientific community could reject the idea, although a pro is that by using this approach the community would be honored. He pointed out that they would get community buy-in and also avoid a power struggle between the state health department and the local community by insisting on other paths. He then said he would like more clarification on why informal theory programs would be more generalizeable.

A group participant said that when the CBO develops the theory they would consider a lot of factors, such as how to reach the clients and how to meet their needs. He said that this kind of theory is easily adapted by other CBO's because it's the real thing, while formal theory only comes from the top – from scientists that don't know what's going on out in the field.

Replication With no Adaptation (yellow):

Pros

- ❑ It's already ready to be implemented – no experimentation or processes are necessary
- ❑ It's easily evaluated – assuming it's implemented as written
- ❑ The probability for success is high
- ❑ The TA needs are clear – know what the interventions are and what will be needed as far as assistance to replicate the programs.
- ❑ It's already been shown to be effective.
- ❑ It would have standardized interventions across a jurisdiction.

Cons

- ❑ It might not be tailored to the populations at risk in that jurisdiction
- ❑ There might not be an intervention or model that has been developed for certain populations
- ❑ It might not be a good match – the population might have certain cultural nuances that would make it inappropriate.
- ❑ There is no local ownership – community members were not involved in the process or development so there might be minimal support or a feeling that the grantees are forcing it down their throat
- ❑ It requires more management to make sure it is being implemented as written
- ❑ Fewer interventions would get funded

Formal Theory (pink):

Pros

- ❑ The plans have already been evaluated – no need to come up with new designs
- ❑ It's concrete – you can see where you're going and what's happening
- ❑ It's efficient

Cons

- ❑ It's too generic – not culturally based or socio-economically based so it creates challenges for those populations different from the groups that have been studied
- ❑ Developing the evaluation is not always possible – some communities don't have the evaluation capacity necessary for carrying out the plans that have been studied and replicated elsewhere
- ❑ The top-down model limits possibilities for research/programming and also tends to be RFP driven (name-dropping of others who have done the same evaluation)

Proven Interventions With Adaptation (Green):

Pros

- ❑ It's already evidence based
- ❑ It can be tailored to the community to receive community buy in
- ❑ The structure is there, but it also has flexibility
- ❑ It has an evaluation component already developed that can be tailored to needs
- ❑ It's building on an established body of knowledge, but still allows for creativity and inclusion of other formal theory
- ❑ It's realistic and the most likely to actually happen and work

Cons

- ❑ There is a risk of losing a key element
- ❑ Risk of not doing what the original intervention designed – could lose efficacy (fitting square peg into round hole)
- ❑ There might not be the expertise or trained staff for the translation
- ❑ There could be a struggle with rigidity ("do this"/ "can't do that")
- ❑ A lot of "take off the shelf and use it" programs don't fit unless they're being used for the same target population

Discussion Summary:

- ❖ A question was asked about the translation of all of those plans into the state or jurisdiction application to CDC and how they are going to take the 90 plans and send them to CDC.

- ❖ Molly Herrmann responded by saying that part of it refers to the population evaluation handout that she discussed and creating a matrix of population by intervention. That is how they will summarize their work for the CDC. They asked agencies to fill one out, even those with 10 or 15 intervention plans, so that they could get an idea of what they were doing, too. Looking at it visually sometimes points out areas where too much emphasis might be placed (heterosexual risk). She explained that they have an intervention plan code assigned to each one that they drop into the population intervention grid.

- ❖ A question was posed about how the technical assistance aspect would be handled when doing a competitive bid. There was a concern about some organizations receiving more information than others.

- ❖ Molly Herrmann said that they have struggled with that to some extent. She referred back to two CBO's that currently provide on-going technical assistance to their peers and she said that those organizations would also be applying for funds. She admitted that it's not the best system. If they have an RFP, they have decided to have a bidder's conference telecast, where everything is recorded and everyone has access to questions/answers. They've gone round and round on it because they don't know if they are unbiased themselves. They have not been able to give any information to inquiring agencies, but they would be able to ask questions at the telecast bidders conference.

- ❖ One participant then mentioned the possibility of developing a coalition of different agencies because he said that one of his regions actually applied as a coalition and

received more money as a result.